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The Use of Outcome Measures by Psychologists in Clinical Practice

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This survey investigated psychologists' use of outcome measures in clinical practice. Of the respondents, 37% indicated that they used some form of outcome assessment in practice. A wide variety of measures were used that were rated by the client or clinician. Clinicians who assess outcome in practice are more likely to be younger, have a cognitive–behavioral orientation, conduct more hours of therapy per week, provide services for children and adolescents, and work in institutional settings. Clinicians who do not use outcome measures endorse practical (e.g., cost, time) and philosophical (e.g., relevance) barriers to their use. Both users and nonusers of outcome measures were interested in similar types of information, including client progress since entering treatment, current strengths and weaknesses, and determining if there is a need to alter treatment. Implications for practicing clinicians are discussed.

As part of normal clinical practice, therapists routinely assess the progress of their clients. For the most part, however, practitioners assess outcome in an informal manner, based on client report and clinical judgment. While standardized outcome assessment is an integral part of psychotherapy research (Ogles, Lambert, & Fields, 2002), it appears that relatively few clinicians in independent practice use any standardized outcome measures or collect data in any form (Phelps, Eisman, & Kohout, 1998). With the growing emphasis on accountability, standardized assessment may become more common in practice. Using formal outcome assessment strategies can provide additional outside validation of the clinical judgment, which can aid practitioners in providing better services for their clients.

One of the most important ways in which outcome assessment can be beneficial occurs when practitioners receive feedback concerning the current level of the client's functioning or the progress that has been obtained since therapy started (Lambert et al., 2001). For example, Howard, Moras, Brill, Martinovich, and Lutz (1996) developed a patient profiling system that includes an estimated expected course of treatment response for each patient based on his or her initial clinical characteristics. With this information, the clinician can use the outcome data to assess progress relative to the expected course of treatment. Similarly, therapists can use aggregate data collection to help them make personal decisions about their own delivery of psychotherapeutic services. For example, Clement (1994) published a quantitative evaluation of 26 years of his private practice and demonstrated how clinicians can use similar information to direct their psychotherapeutic services. Clement asserted that assessing outcome is not only good for practitioners and their potential clients, but that it is an ethical obligation.

In spite of the potential benefits, it appears that few clinicians engage in standardized outcome assessment. In one of the few studies examining the use of outcome measures in routine practice, the American Psychological Association (APA) Committee for the Advancement of Professional Practice (CAPP) surveyed psychologists about the effects of managed health care on their practices (Phelps et al., 1998). One of the items in the questionnaire asked whether the psychologist used an outcome measure. Of the sample, 29% reported using some form of outcome measurement in their clinical practice, with 60% of those using a standardized measure (e.g., Beck Depression Inventory, Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Symptom Checklist–90, Derogatis, 1983; Minnesota Multiphasic Personality Inventory, Butcher et al., 2001; etc.) and 40% using an unstandardized outcome measurement.

In further analysis, they found that independent practitioners reported the lowest rate (24%) of outcome measure use, with academic and government-based practitioners reporting 34% and 35%, respectively. Those working in medical settings reported the highest proportion, at 40%. There was also a trend indicating that clinicians who received their licensure most recently were more likely to use outcome measures.

Bickman et al. (2000) conducted a survey to assess child and adolescent clinicians' values and attitudes about outcome assessment. Of 539 respondents, 23% reported that they used standardized outcome measures with their adolescent clients. The top five pieces of information that clinicians valued included the following: history of maltreatment, past and present youth stressors, family functioning, quality of parent–youth relationship, and therapeutic alliance, in that order. They also found that a large percentage of practitioners were interested in participating in outcome research and would like to receive outcome information about their clients at intake, during treatment, and after termination.

If it is true that a large percentage of practitioners are interested in conducting regular outcome assessment, then why is the percentage of users so small? There are several potential barriers to

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implementing an outcome-assessment strategy, many of which are discussed later in this article. Yet despite these barriers, there are indications of a trend for increased outcome measure use (Phelps et al., 1998). Private insurance companies and managed care companies are increasingly requiring practitioners to administer outcome-assessment instruments to make decisions about optimally effective and efficient services. Work settings in the public sector are also becoming involved in outcome assessment. Because of external pressures to assess outcome, the degree to which practitioners use outcome measures might be a function of both the work setting and/or the primary source of income. In addition, increased training and understanding of how tracking client change can be beneficial has likely increased the percentage of practitioners who use outcome measures in their clinical work.

No studies, however, have attempted to ask the practitioners themselves why they do (or do not) use outcome measures in their clinical practice. Thus, we conducted this survey to better understand who is using outcome measures and to assess factors (such as work setting, clientele, source of income, and others) that may influence whether clinicians are using outcome measures in their practice. Another important aspect of this study was to determine what information clinicians find useful on an outcome measure, thus extending the findings of Bickman et al. (2000) to a broader sample of clinicians. For clinicians using an outcome measure, this study also examined which outcome measures are being used. A final aim of this study was to elucidate practitioners' reasons for using and not using outcome measures.

The Practitioner Outcome Survey

We surveyed a national sample of psychologists. The sample was randomly selected by the APA research office from members of the APA. To include practicing therapists in the national sample, only licensed practitioners in the United Sates and psychologists who paid the special practice assessment fee were included. Of 2000 surveys mailed, approximately 600 surveys were returned after the first mailing. We mailed the remaining 1,400 participants an identical second survey approximately 3 to 4 weeks after mailing the original survey.

After the responses from the second mailing were collected, a total of 996 (49.8%) of the 2,000 practitioners in the sample responded. Of the respondents, 122 reported being retired, reported conducting 0 hours of therapy per week, or chose not to participate in the study. These participants were eliminated from further analyses. The remaining 874 surveys were 43.7% of the original 2,000 surveys mailed and 46.3% of the 1,886 potential surveys.

The survey consisted of three sections, each of which was on a separate page. The first section contained basic demographic questions that were used to compare the two groups (outcome-measure users and outcome-measure nonusers). The second section of the survey was completed by practitioners who indicated that they did use outcome measures and asked questions about how and why they used the measures. They also indicated what measures they were using and what information they found important on outcome measures. The third section, completed by respondents who indicated that they did not use outcome measures, asked questions about why they did not use outcome measures and then had them rate the importance of information that an outcome measure might provide (the list of information was identical to the list that users rated). The final question in this section asked how interested the practitioners were in receiving feedback about clients' relative progress and current functioning.

For this sample ($N = 874$), several demographic characteristics are detailed in Table 1, such as gender, degree, clientele, work setting, source of income, and theoretical orientation. Practitioners reported conducting therapy for an average of 22.7 hr per week ($SD = 11.7$), with 1 hr per week being the lowest and 70 hr being the highest reported. As for the year of first licensure, the earliest date reported was 1963, with the most recent being 2001. The average number of years since first licensure for the entire sample was 18.0 ($SD = 7.4$).

Use of Outcome Measures

In response to the question, "Do you use some form of outcome assessment in your practice?" 37.1% stated that they did (62.9% did not). Of the 37% that reported using outcome assessment in their practice ($n = 324$), 193 endorsed using both standardized and individualized/unstandardized outcome measures. Twenty-eight percent of outcome users reported using no individualized measures at all, while 12% indicated that they did not use any standardized measure.

In total, 324 respondents reported using some form of outcome assessment in their practice. Of those, 74.4% reported that the

Table 1
Sample Demographics

Demographic	Percentage of sample
Gender	
Male	52
Female	48
Highest degree	
PhD	85
PsyD	10
Clientele	
Children/adolescents	14
Adults	62
Both	23
Work setting	
Solo private practice	46
Group private practice	14
Medical center/hospital	7
University/college	6
Community mental health	3
School system	3
Outpatient clinic	3
Source of income	
Managed care	32
Fee for service	28
Private insurance	20
Medicaid/medicare	8
Government entities	5
Grant funding	2
Theoretical orientation	
Eclectic	30
Cognitive	29
Psychodynamic/psychoanalytic	20
Behavioral	8
Interpersonal	6
Humanistic	2
Existential	2

client completed outcome measures. A majority (61.2%) also reported that the therapists completed outcome measures. In addition to clients and therapists, 12.8% of respondents indicated that significant others complete outcome measures, 4.5% reported that parents complete measures, 4.2% reported that teachers completed measures, and 5.5% indicated that individuals other than those listed above completed the measures.

Frequencies of standardized and individualized outcome measures that respondents endorsed are contained in Table 2. Only measures that were endorsed by more than 5% of users are included. Eighteen measures were endorsed by less than 5% of the respondents but were indicated more than once, with an additional 125 measures identified by respondents that were mentioned only one time.

Respondents were asked to rate why they used outcome measures as part of their practice. Ratings were based on a 6-point scale (0 = *not important*, 5 = *very important*). Reasons are listed (Table 3) in order of the highest mean ratings.

Respondents who reported not using outcome measures (n = 550) rated possible reasons they did not use any measures. They completed a scale similar to the one completed by outcome users (0 = *not a reason*, 5 = *very important*). The results are listed in Table 4. Individuals who completed the page for outcome nonusers also were asked how interested they would be in using an outcome measure to collect information about clients' relative progress and current level of functioning. The mean rating on a 6-point scale (0 = *not at all*, 5 = *very much*) was 2.19 (SD = 1.46).

User and Nonuser Comparisons

We made several comparisons between respondents who reported using some form of outcome assessment and those who indicated that they did not. These are detailed in Table 5. Specifically, it should be noted that practitioners in solo or group practice were significantly less likely to use outcome measures than those who worked in institutional settings. Practitioners whose primary source of income was managed care/private insurance or fee-for-service were less likely to use outcome measures than were those whose primary source of income was from institutionalized sources. Cognitive or behavioral practitioners were more likely to use outcome measures than both insight-oriented therapists and practitioners who labeled themselves eclectic. Eclectic practitioners were more likely to use outcome measures than were insight-oriented therapists.

Outcome-measure users and nonusers also differed, $t(863) = 2.52$, $p < .05$, in how many hours per week they conducted psychotherapy. Outcome-measure users conducted a mean of 23.48 hr (SD = 11.91) of therapy, and nonusers conducted a mean of 21.40 hr (SD = 11.27). A significant difference was also found in the number of years since licensure for the two groups, $t(861) = 2.17$, $p < .05$. Outcome-measure users averaged 17.27 years (SD = 7.06) since licensure, with nonusers averaging 18.40 years (SD = 7.59) since licensure.

In response to the question asking how much training the practitioner had in using outcome assessment (0 = *not at all*, 5 = *very much*), outcome-measure users had a mean rating of 3.39 (SD = 1.28) compared with 2.23 (SD = 1.46) for nonusers. This difference was significant, $t(735) = 12.20$, $p < .001$. We also

Table 2
Most Commonly Used Standardized and Individualized Outcome Measures

Outcome measure	Frequency	Percentage of total users
Standardized		
Beck Depression Inventory	146	45.3
GAS/CGAS	74	23.0
CBCL	68	21.1
Structured Clinical Interview	61	18.9
SCL-90-R or BSI	46	14.3
Beck Anxiety Inventory	20	6.2
OQ-45	18	5.6
Other (used more than once)	87	27.0
Other (used only once)	125	38.8
Indicated no standard measure	60	18.6
Individualized		
Individualized target behaviors	166	51.7
Target complaints	105	32.7
Goal attainment scaling	55	17.1
Other	37	11.5

Note. GAS/CGAS = Global Assessment Scale/Children's Global Assessment Scale; CBCL = Child Behavior Checklist; SCL-90-R = Symptom Checklist-90-Revised; BSI = Brief Symptom Inventory; OQ-45 = Outcome Questionnaire.

Table 3
Reasons Practitioners Use Outcome Measures

Reason	*M*	*SD*
Track client progress	4.14	1.32
Determine if there is a need to alter treatment	3.64	1.64
Ethical practice	3.56	1.50
Determine strengths and weaknesses	2.03	1.79
Required by MCO/insurance	1.69	1.88
Required by work setting	1.41	1.94
Research publication	0.80	1.47
Business marketing	0.58	1.21
Other	0.24	1.02

Note. MCO = managed care organization.

Table 4
Reasons Practitioners Do Not Use Outcome Measures

Reason	*M*	*SD*
Adds too much paperwork	2.95	1.83
Takes too much time	2.77	1.80
Extra burden on clients	2.38	1.75
Feel it is not helpful	2.37	1.85
Do not have enough resources	2.30	1.90
A simple measure distorts the effects of treatment	1.94	1.89
Do not know how to implement a strategy	1.39	1.69
Concerns about confidentiality	1.36	1.71
Feel that it will be misused by others	1.28	1.64
It interferes with my autonomy as a provider	1.04	1.53
Do not know how to interpret scores	0.91	1.49
Client refusal	0.72	1.22
Other	0.62	1.61

Table 5
Outcome Measure Users and Nonusers Comparisons

Demographic	Percentage who use outcome measures	Significant difference			
		χ^2	*df*	*N*	*p*
Gender					
Male	40				*ns*
Female	34				
Highest degree					
PhD	37				*ns*
PsyD	39				
Clientele					
Children/adolescents	54	21.43	2	862	<.001
Adults	32				
Work setting					
Solo private practice[a]	29	26.74	2	745	<.001
Group private practice[b]	35				
Institutional work setting[a,b]	50				
Source of income					
Fee for service[c]	30	13.81	2	833	<.01
Managed care/private insurance[d]	36				
Institutionalized sources[c,d]	48				
Theoretical orientation					
Cognitive–behavioral[e,f]	50	42.52	2	841	<.001
Insight oriented[e,g]	24				
Eclectic[f,g]	36				

Note. Additional significant comparisons follow: [a] $\chi^2(1, N = 624) = 26.53, p < .001$; [b] $\chi^2(1, N = 342) = 7.16, p < .01$; [c] $\chi^2(1, N = 384) = 13.68, p < .001$; [d] $\chi^2(1, N = 592) = 7.28, p < .01$; [e] $\chi^2(1, N = 576) = 41.58, p < .001$; [f] $\chi^2(1, N = 578) = 12.60, p < .001$; [g] $\chi^2(1, N = 528) = 8.38, p < .01$.

asked how beneficial practitioners believed it would be for them to receive training on how to use and interpret outcome measures (same 0–5 scale). Outcome-measure users had a mean rating of 2.91 ($SD = 1.57$), and nonusers had a mean rating of 2.12 ($SD = 1.49$). This difference was also significant, $t(857) = 7.40$, $p < .001$.

Both outcome-measure users and nonusers used the same set of items to rate what information they found (or thought they would find) useful or important on an outcome measure. The ratings are based on a 6-point scale (0 = *not important*, 5 = *very important*). Mean ratings for each item with their respective rank order in parentheses are contained in Table 6.

Implications for Practitioners

Several of the findings of this study are important in gaining a better understanding of current practices in professional psychology. We hope that this better understanding will lead to improvements in everyday clinical practice and will result in clinicians making informed decisions about their own outcome-assessment strategies.

The first aim of this survey was to gather information about outcome assessment among psychologists in clinical practice. In contrast to earlier surveys, a surprising 37% of respondents reported gathering outcome data of one form or another. This is higher than the 29% of respondents in the CAPP (Phelps et al., 1998) study and the 23% who reported using standardized measures in Bickman et al.'s (2000) study of clinicians involved in practice with children or adolescents. The proportion of child/adolescent clinicians who reported using outcome measures in this sample was even higher (54%).

Although some variability in surveys can be expected, the increased percentage may also reflect changes in the field. The CAPP survey was mailed 6 years prior to the current study. With the spreading influence of managed care and other institutional pressures for accountability, plus an increase of training in the potential benefits of outcome assessment, this change might represent a shift in the field toward an increased use of outcome measures as part of clinical practice. If the current trend continues,

Table 6
Information Practitioners Find Useful

Type of information	Users' mean rating (rank)	Nonusers' mean rating (rank)
Progress since intake	4.29 (1)	4.00 (1)
Overall level of functioning/problem severity	4.16 (2)	3.72 (3)
Social functioning/relationships	3.57 (3)	3.49 (5)
Therapeutic gains maintained	3.45 (4)	3.81 (2)
Symptom scores for specific problems	3.41 (5)	3.13 (9)
Satisfaction with services received	3.08 (6)	3.51 (4)
Client skills and strengths	3.00 (7)	3.28 (6)
Substance abuse and suicide warning	2.93 (8)	3.17 (7)
Client motivation to change	2.92 (9)	3.16 (8)
Compliance with treatment plan	2.84 (10)	2.66 (13)
Therapeutic alliance	2.50 (11)	3.03 (10)
Social support	2.34 (12)	2.72 (12)
Reasons for seeking services	2.28 (13)	2.39 (14)
Open-ended responses on goal attainment	2.28 (14)	2.77 (11)
Other	0.15 (15)	0.11 (15)

an increasing number of practitioners will be using outcome measures in the future.

Clinicians who are presently using outcome measures as part of their clinical practice indicated several reasons for doing so. When respondents were asked to rate the reasons why they use outcome measures as part of their practice, "tracking client progress" was rated quite high and was the most important reason given by outcome users. This may reflect clinicians' interest in a more standardized method of evaluating treatment effectiveness that extends beyond informal client reports of progress. Related to tracking client progress, the second highest rated reason for using outcome measures was "to determine if there is a need to alter treatment."

For both outcome-measure users and nonusers, "progress since intake" was rated as the most useful type of information that an outcome measure produces. Other items that were rated high on users' lists of desired information from outcome measures were "overall level of functioning and/or problem severity," "social functioning/relationships," "information concerning whether therapeutic gains were maintained," and "symptom scores for specific problems." The higher ratings seem to involve the functioning of the client and therapeutic improvement, indicating that clinicians are using outcome measures as a gauge of therapeutic progress in their individual clients. For nonusers who rated the same items on the basis of importance if they were to use outcome measures, the highest ratings also seem to involve the functioning of the client and therapeutic improvement. The overall similarity indicates that both users and nonusers appear to value the same information that an outcome measure might provide.

When tracking client progress using standardized measures, clinicians can have data available to help them know when new or different strategies may be needed to improve treatment. For example, creating dose–effect curves and therapist-feedback systems are two tools that can be beneficial to the therapist conducting psychotherapy and can aid the therapist in making treatment plan decisions. Lambert et al. (2001) found that giving clinicians feedback concerning client change (as assessed by an outcome measure) resulted in better therapeutic outcome and more therapy sessions for clients who were at a high risk for treatment failure. Therapists can also aggregate data to help them make personal decisions about the effectiveness of their own delivery of psychotherapeutic services. Interested clinicians can look to a number of sources for information about several of these methods (see Clement, 1994; Howard et al., 1996; Lambert, 2001; Lambert et al., 2001; Leon, Kopta, Howard, & Lutz, 1999; Lyons, Howard, O'Mahoney, & Lish, 1997; Ogles et al., 2002). As these writers have pointed out and in some cases demonstrated, outcome assessment can be as much an applied science as it is a research enterprise.

Clinicians also used outcome measures in practice for reasons other than gauging therapeutic progress. However, reasons such as outcome assessment is "required by managed care/insurance companies," "required by the work setting," and "business marketing" all rated relatively lower. Despite these other reasons, these findings suggest that more clinicians may be using outcome measures because of a change in views and *not* because of increased pressure from external sources. Some have hypothesized that external forces related to the business aspect of clinical practice (Geraty, 1996; Lyons et al., 1997; Pike-Urlacher, Mackinnon, & Piercy, 1996), such as managed care and insurance company requirements, were significant reasons that practitioners are using outcome measures. Yet, according to this sample of practitioners' responses, outcome measures are used more for the information that they provide than because of external pressure.

One finding in this study that is of particular importance to practitioners currently using outcome measures, and for those who are considering beginning an outcome-assessment strategy, is the incredible variability in outcome measures used by clinicians in this sample. Several well-known instruments were often used such as the Beck Depression Inventory (Beck et al., 1961), the Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), the Symptom Checklist–90 (Derogatis, 1983), and the Child Behavior Checklist (Achenbach, 1991). Despite the prevalence of these more common outcome measures, an amazing diversity of standardized instruments used for outcome assessment was reported: 125 instruments were used by only one clinician each! Many of these measures are not common in the research literature, and it is unclear whether these measures are idiosyncratic to the agency in which the respondent worked or whether any psychometric data exists supporting their utility as effective outcome measures. The measurement chaos evident among the standardized measures is compounded by the fact that many clinicians use unstandardized ratings of individualized behavioral targets to assess outcome. Together this finding of measurement diversity serves to reinforce the notion that there is no universally accepted measure of outcome used by clinicians.

Just as good research needs reliable and valid dependent measures, the quality of clinical outcome assessment also requires sound dependent measures. A poor outcome measure can provide inaccurate information about symptom severity and client progress. The most obvious ramifications of this are that clinicians might be basing certain treatment decisions on unreliable information. To provide the best possible services to their clients, it would be wise for clinicians to carefully select outcome measures with demonstrated validity and reliability, so that they can be accurately informed concerning client progress. The search for measures that can be completed quickly while providing sufficient information is an ongoing process. There are resources to which clinicians can turn to evaluate measures that would be appropriate for their own clinical needs (Maruish, 1999; Ogles et al., 2002; Ogles, Lambert, & Masters, 1996). While considering the feasibility of certain measures, it would behoove clinicians to contemplate the type of information that they would find useful. This study details information that a large sample of clinicians indicated was important.

Despite the trend of increasing numbers of clinicians using outcome measures, the fact remains that a majority do not. Though others have suggested reasons why more practitioners are not using outcome measures as part of their clinical practice, this study is the first to directly ask clinicians why they do not. Those who reported not using any outcome measures rated a collection of reasons for not doing so that might come under the general heading of *practical reasons*, such as "it adds too much paperwork," "takes too much time," "adds an extra burden on clients," or "insufficient resources." A secondary but often-endorsed collection of reasons for not using outcome measures involved the attitude or belief that outcome measurement is not helpful or relevant to practice. In addition to these reasons, other practitioner attitudes such as "concerns about confidentiality," "misuse by others," and "interference

of practitioner autonomy" did not rate as highly as did practical barriers to using outcome measures.

There are likely a number of practitioners today who are interested in conducting routine outcome but are restricted from doing so by practical limitations. This is a likely explanation for the finding that practitioners in an institutional work setting (medical center/hospital, university/college, community mental health, etc.) were more likely to use outcome measures than practitioners in a solo or group private practice. It is probable that these more institutional work settings have more resources for conducting routine outcome assessments. It is also possible that most of the clinicians who work in institutional settings receive much of their income from Medicaid/Medicare, grants, or other government sources (grouped together as institutional sources of income in this analysis).

For both individual practitioners and clinical administrators wanting to start or enhance existing outcome-assessment strategies in their clinical practice, the practical barriers to doing so are a daunting obstacle that needs to be overcome. More creative methods of dealing with these practical limitations are needed. It would be helpful for the field if clinicians who have working systems that require fewer resources would publish their successful methods. Improvements in technology may alleviate some practical constraints that limit the use of outcome measures.

Practitioners may also have philosophical grounds for choosing not use outcome measures. Not surprisingly, insight-oriented therapists were less likely than cognitive or behavioral therapists to use outcome measures. The eclectic group, which may contain a mixture of cognitive-behavioral and insight-oriented practitioners, was more likely to use outcome measures than the insight-oriented group and was less likely to use measures than the cognitive–behavioral group. These differences may reflect differences in training emphasis related to outcome assessment or basic philosophical differences in the nature of assessment in general. In addition, it is possible that insight-oriented practitioners believe that the targets of treatment are not easily measured in the form of symptoms, behaviors, or other overt constructs. This creates a need for various outcome measures (that are both reliable and valid) that can satisfy the needs of different theoretical orientations.

This study found that those clinicians who use outcome measures have received a substantial amount of training in the use and implementation of outcome-assessment strategies relative to those who do not use outcome measures. It is important to notice the significant effect training can have on practitioners' behavior, and presumably on their attitudes. At the least, it is recommended that practitioners receive further training on the clinical utility of outcome assessment, in order to be better informed when deciding whether to engage in such an endeavor.

Before concluding, the representativeness of this sample must be addressed. First, it appears from demographic information that therapists who participated in this study were representative of the original sample of 2,000 practitioners randomly selected by the APA Research Office. Gender and highest degree for both groups were within one percentage point. The work-setting information provided by APA for the current sample differed slightly from this study but is fairly consistent. Independent practice was 56.7% in the original sample, while 60.1% of respondents worked in either solo or group private practices. In comparison to the CAPP survey (Phelps et al., 1998), which used the same selection criteria as the current study, the breakdown of gender shows that the current study's distribution of 52% male and 48% female more closely represents APA membership (the CAPP survey slightly overrepresented men with 55% men to 43% women). This study and the CAPP study demonstrated an equal proportion of PhD, PsyD, and EdD as the highest degree earned by respondents (85%, 3%, 2% and 84%, 6%, 5%, respectively).

Certainly 85% of professionals who deliver therapeutic or counseling services do not hold a doctoral degree, though the aim of this study was to assess outcome measure use by practicing psychologists. The sample does, however, have some representative strength. There is a good mix of practitioners who administer services to both children and adults. The average number of hours conducting therapy per week was just under 23, which seems reasonable. Considering the grouping of theoretical orientations used for the comparative analyses, there is a reasonable division of eclectic, insight-oriented, and cognitive or behavioral therapists. There is also an almost even gender split. Nevertheless, the findings of this study must be considered in the context of its limitations in generalizability. Many mental health professionals do not hold doctoral degrees. In addition, many of the respondents in this study have a significant research background from their training in scientist–practitioner programs. This might be a factor in using outcome measures that would not generalize to other professionals. More research will be needed to gain a better perspective on outcome-measure use for all mental health professionals.

Conclusions

There is a trend for more clinicians to be using outcome measures in their practice, and the primary reasons for doing so are directed at tracking client change, potentially signaling a need to alter the treatment plan if necessary. Preliminary research is suggesting that the benefits of using measures as part of clinical practice are important. Practitioners' service to clients might be enhanced in several ways through the use of outcome measures, some of which were only briefly described here. As these findings become better understood, there will likely be an increased call for the implementation of outcome assessment as routine practice. Indeed, it is recommended that those clinicians who are interested in a more thorough examination of these possibilities should make a careful consideration of the studies cited in this article. If more clinicians are to use outcome measures, however, certain concerns need to be considered. In particular, practical limitations must be addressed before many clinicians will be interested in or able to use outcome measures in a routine manner.

A final caution needs to be made about the interpretation of outcome-measures data. As with other sources of clinical information, outcome measures provide only one source of information. While this can be quite useful, practitioners must ultimately rely on clinical judgment in making treatment decisions. Outcome measures serve to provide additional standardized information for consideration. Clinicians should be particularly cautious in interpreting data from idiosyncratic measures that do not have established reliability or validity.

Overall, this study provides important yet initial data about outcome measures use by independent practitioners. Further study of those who do and do not use outcome measures may serve to inform the search for methods of helping clinicians to evaluate

their practice. Developing methods for assessing outcome that overcome practical and philosophical barriers may help to provide reasonable methods for tracking client progress and therefore improve psychological services.

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